MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10794 — Reg. Dist. No. 10786

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Riverside Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEWIS — Middle ALEXANDER — Last ABBOTT

4. DATE OF DEATH: Month September — Day 4 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/27/1918

9. AGE (In years last birthday): 43 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Improvements

10b. KIND OF BUSINESS OR INDUSTRY: contracting

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oscar W. Abbott

14. MOTHER'S MAIDEN NAME: Rita Mowbray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-18-5186

INFORMANT — Address: Mrs. Lewis A. Abbott, same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b) Hypertensive Cardio Vascular Disease

DUE TO

(c) Chronic Glomerulo Nephritis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1957, to Sept 4, 1961, that I last saw the deceased alive on Sept 3, 1961, and that death occurred at 9:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill, Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Rd, Salisbury, Md. — DATE SIGNED: 9/4/61

PHYSICIAN'S NAME (Type): THOMAS C. HILL, Jr. — Pine Bluff Rd. — Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/6/1961

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson F.H. — ADDRESS: Salisbury

24a. REC'D BY REGISTRAR — DATE: SEP 6 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krouse

Franklin B. Hill

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 3 may be detained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10795

CERTIFICATE OF DEATH

Item 7 Film G297 10/6/61 iwk

10787

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where decreased lived, If institution: Residence before admission)
e. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Horace — Middle: Seth — Last: Adams

4. DATE OF DEATH: Month: September — Day: 25 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: Sept 11, 1897

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR — Months: | Days:
IF UNDER 24 HRS. — Hours: | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Somerset Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Seth Adams

14. MOTHER'S MAIDEN NAME: Sarah Lankford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 219-03-2210

17. INFORMANT — Address: Mrs. Mary Johnson, Princess Anne Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO (b): Hypertensive Cardio Vascular Disease — 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on Sept 25 1961, and that death occured at 3:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: B. Frank Gigante M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): B. FRANK GIGANTI

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/28/61

23c. NAME OF CEMETERY OR CREMATORY: Pitts Creek Presbyterian

23d. LOCATION (City, town or county) (State): Pocomoke City Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Horace Dennis Princess Anne, Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10796

CERTIFICATE OF DEATH

Item 9 Film G296 9/28/61 jwk

10788

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 712 N. Div. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ARTHUR — Middle: WILLY — Last: ANGER

4. DATE OF DEATH: Month: 9 — Day: 22 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 28, 1881

9. AGE (In years last birthday): 80 / 79 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Tool & Deye Maker

10b. KIND OF BUSINESS OR INDUSTRY: Tools

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknow

14. MOTHER'S MAIDEN NAME: Unknow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Howard Anger, Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Coronary Arteriosclerosis.
DUE TO (c): (Arteriosclerotic Heart Disease)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 2 0 . 0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia - Probably due to Intestinal Tumor

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 19, 1961 to Sept 22, 1961, that (I) (we) last saw the deceased alive on Sept 22 1961, and that death occured at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-25-1961

22c. PHYSICIAN'S NAME (Type): Dr. Thomas C. Hill M.D.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-25-61

23c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery

23d. LOCATION (City, town or county) (State): Shad Point, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Funeral Home Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kimes

Norman T. Baker

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10797

CERTIFICATE OF DEATH

10789

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1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
a. STATE: Md
b. COUNTY: Worcester ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 23X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Luther — Middle: M. — Last: Atkinson

4. **DATE OF DEATH**: Month: September — Day: 15 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 10 1893

9. AGE (In years last birthday): 67 10/5 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY: Peoples Life Insurance Co.

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel M. Atkinson

14. MOTHER'S MAIDEN NAME: Sarah Powell

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service): Yes World War I

16. SOCIAL SECURITY NO.: 217-05-1340

17. INFORMANT — Address: Mrs Mary J Atkinson, Snow Hill, Md

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

331X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from August 25, 1961 to September 15 1961, that (I) (we) last saw the deceased alive on September 15 1961, and that death occured at 4:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Willard R. Ellis Jr. M.D.

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 9-15-61

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 18/61

23c. NAME OF CEMETERY OR CREMATORY: Bates Methodist

23d. LOCATION (City, town or county) (State): Snow Hill, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Elay E. Dennis — ADDRESS: Snow Hill, Md

25a. REC'D BY REGISTRAR DATE SEP 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10798

CERTIFICATE OF DEATH

10790

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b: 12

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 305 Washington St

d. STREET ADDRESS: 305 Washington St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLOTTE Middle ADELINE Last BOZMAN

4. DATE OF DEATH: Month SEPT. Day 13th Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 2, 1886

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months 7 Days 11 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shirt Factory Employee

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Dames Quarter, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Wesley Bozman

14. MOTHER'S MAIDEN NAME: Ella Rebecca Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Robert W. Bozman (Brother) Address: 305 Washington St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO (b): Arteriosclerotic Coronary Thrombosis
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 9-13 1961 to 9-13 1961, that (I) (we) last saw the deceased alive on 9-13 1961 and that death occurred at 1:15 P. M., from the causes and on the date stated above.

22a. SIGNATURE: Wilbur R. Ellis Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Sept. 15/1961

22c. PHYSICIAN'S NAME (Type): Dr. Wilbur R. Ellis Jr

22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 16, 1961

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 19 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10799 10791

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pemberton Drive & Parsons Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 735 Jackson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AUSTIN — Middle YOUNG — Last BRIDGE

4. DATE OF DEATH: Month SEPT. — Day 2nd — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1886

9. AGE (In years last birthday) 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinest-Boat Co.

10b. KIND OF BUSINESS OR INDUSTRY: (Employee-Laborer)

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: (Unk)

14. MOTHER'S MAIDEN NAME: (Unk)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mary S. Bridge (Wife) Address: 735 Jackson St Salisbury, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Burns 100 % Body Surfaces — INTERVAL BETWEEN ONSET AND DEATH: Instant

816X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Driver of Auto Collided w Truck

20c. TIME OF INJURY Hour 10 a.m. p.m. — Month, Day, Year 9/2 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) Wicomico - Salisbury - (County) Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Earl L Royer M.D.

EXAMINER'S NAME (Type) Dr. Earl L. Royer

Address (Street, city, town, or county) 407 Camden Ave. Salisbury, Md

DATE SIGNED Sept. 5 /1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 5. /61

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or country) Salisbury, Maryland (State)

23. FUNERAL DIRECTOR HOLLOWAY & COMPANY — **ADDRESS** SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE SEP 8 '61

24b. REGISTRAR'S SIGNATURE Arthur S Truitt

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10800 10792

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 306 N. Division St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anthony — Middle: Charles — Last: Brown

4. DATE OF DEATH: Month: September — Day: 26 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 29, 1950

9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Boy

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): New York City N.Y.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James Edward Brown

14. MOTHER'S MAIDEN NAME: Anna Marie Heron

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mr. James E. Brown (Father) Apt. 205A Patrict Henry Air Port Newport News, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lympho Sarcoma — INTERVAL BETWEEN ONSET AND DEATH

200.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 19 60 to Sept 26, 1961, that (I) (~~we~~) last saw the deceased alive on Sept. 26 1961, and that death occured at 9:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/26/61

22c. PHYSICIAN'S NAME (Type): Dr. Thomas C. Hill Jr

22d. ADDRESS: Pine Bluff Road, Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 28, 1961

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 28 '61

25b. REGISTRAR'S SIGNATURE: C... S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10801 — 10793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 12 Hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Delaware — b. COUNTY: Sussex
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville
   d. STREET ADDRESS: RFD
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

4-6 X-3

3. **NAME OF DECEASED** (Type or print): First: LEWIS — Middle: T. — Last: BUNTING

4. **DATE OF DEATH**: Month: SEPTEMBER — Day: 29 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 3, 1891

9. AGE (In years last birthday): 70 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Bunting

14. MOTHER'S MAIDEN NAME: Sarah Stephens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-24-3495

17. INFORMANT — Address: Mrs. Ethel Bunting Selbyville, Del

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c):

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease; Rhes

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/28, 1961 to 9/29, 1961 that (I) (we) last saw the deceased alive on 9/29 1961, and that death occured at 3:17 A M, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): David J. Gilmore

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/2 61

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F.

23d. LOCATION (City, town or county) (State): Bishopville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Peter Wholey — ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: OCT 2 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10802

CERTIFICATE OF DEATH

10794

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 10 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Springhill Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILMINGTON
d. STREET ADDRESS: 728 E. 22nd St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: B. — Last: Butler

4. DATE OF DEATH: Month: Sept. — Day: 12 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5-23-1889

9. AGE (In years last birthdey): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, aven if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & Stete, or foreign country): CHINCOTEAGUE

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Levin Booth

14. MOTHER'S MAIDEN NAME: Janie Bowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Miss. Nevada Downs, Berlin Md.

18. CAUSE OF DEATH [Enter only one ceuse per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
DUE TO (b): Hypertensive Cardiovascular Disease — 1 yr.
Conditions, if eny, which gave rise to immediete ceuse (a), steting the underlying ceuse lest. DUE TO (c):

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. / p.m. — Month, Day, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stete)

21. I certify that (I) (this hospital) attended the deceased from Oct. 30, 19 60 to 9/12, 19 61, that (I) (we) last saw the deceased alive on 9/10 19 61, and that death occured at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): David J. Gilmore

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/15/61

23c. NAME OF CEMETERY OR CREMATORY: Evergreen

23d. LOCATION (City, town or county) (State): Berlin MD

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE SEP 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Knaus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10803 10795

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 11 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
   d. STREET ADDRESS: Route # 3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Dave — Middle — Last: Byrd

4. **DATE OF DEATH**: Month: Sept. — Day: 17 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/15/1878

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Morris Byrd

14. MOTHER'S MAIDEN NAME: Mary Stevenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** — Address: Chester White, Princess Anne, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis	1 day
DUE TO (b)	Generalized arteriosclerosis	5 years
DUE TO (c)		

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this Hospital) attended the deceased from Sept. 6, 1961, to Sept. 17, 19 61 that (I) (we) last saw the deceased alive on Sept. 17 19 61, and that death occured at 6:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/18/61

22c. PHYSICIAN'S NAME (Type): Lee L. Lawry, M. D.

22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/20/61

23c. NAME OF CEMETERY OR CREMATORY: Rhodes

23d. LOCATION (City, town or county) (State): Denton Md

24 FUNERAL DIRECTOR'S SIGNATURE: William H. James Jr. Princess Anne

ADDRESS

25a. RECEIVED BY REGISTRAR DATE: SEP 22 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10804 — Reg. Dist. No. 10796

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 12
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1408 Hammond Street. (Christian)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: CHRISTIAN

4. DATE OF DEATH: Month: SEPTEMBER — Day: 5 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17.1912

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — IF UNDER 24 HRS.: Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Upholster, At Chris Craft Corp.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicklas Christian

14. MOTHER'S MAIDEN NAME: Agnes Rhinschmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Margaret E. Christian (Wife) — Address: 408 Hammond St, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/4, 1961, to 9/5, 1961, that I last saw the deceased alive on Sept. 5, 1961, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore, M.D. — ADDRESS (Street, city or town, state): Salisbury Maryland — DATE SIGNED: 9/6/61

PHYSICIAN'S NAME (Type): Dr. David J. Gilmore — Medical Center, Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 8.61.
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park.
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Holloway & Company, Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: SEP 8 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

Item 4 Film G295 9/19/61 iwk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10805

CERTIFICATE OF DEATH

Reg. Dist. No. 10797

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
d. STREET ADDRESS: Snow Hill Road 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Elmer Middle: Tubman Last: Dashiell

4. DATE OF DEATH: Month: September Day: 9 Year: 1961.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-16-1899

9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR Months: IF UNDER 24 HRS. Days: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Tidewater Fisheries

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Dashiell

14. MOTHER'S MAIDEN NAME: Lita Heath

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs Addie Dashiell Address: Salisbury Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardio Vascular Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 8, 1961, to Sept 9, 1961 that I last saw the deceased alive on Sept 9, 1961, and that death occurred at 5:19 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md DATE SIGNED: 9/9/61

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-11-61

22c. NAME OF CEMETERY OR CREMATORY: Ocala Cemetery

22d. LOCATION (City, town, or county) (State): Ocala Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis R. Watson ADDRESS: Princess Anne Md

24a. REC'D BY REGISTRAR DATE: SEP 14 '61

24b. REGISTRAR'S SIGNATURE: Lucretia E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10806

CERTIFICATE OF DEATH

10298

1

M

I

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield — 1939-2
d. STREET ADDRESS: Richardson Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Lester — Last: Daugherty

4. DATE OF DEATH: Month: September — Day: 24 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 11, 1892

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Hancock

14. MOTHER'S MAIDEN NAME: Aurelia Phippin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Oscar Daugherty, Baltimore, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal failure — INTERVAL BETWEEN ONSET AND DEATH: 450'0
DUE TO
(b): Generalized arteriosclerosis, Congestive
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c): Heart failure, chronic

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 9/4, 1961, to 9/24, 1961, that I (we) last saw the deceased alive on 9/24 1961, and that death occured at 12:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: W. F. Holdefer Jr. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 9/25/61

22c. PHYSICIAN'S NAME (Type): W. F. HOLDEFER

22d. ADDRESS: Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/27/61
23c. NAME OF CEMETERY OR CREMATORY: Crisfield Cem.
23d. LOCATION (City, town or county) (State): Crisfield, Md

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bradshaw & Sons, Crisfield, Md

25a. REC'D BY REGISTRAR DATE: SEP 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10807

CERTIFICATE OF DEATH

10799

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
c. LENGTH OF STAY IN 1b: 45 Yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pittsville

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Ocean City Blvd.,
d. STREET ADDRESS: Ocean City, Blvd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE COVINGTON — Middle — Last DAVIS
4. DATE OF DEATH: Month 9 — Day 7 — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-24-1877
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Bookeeper
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Goldsbury Davis
14. MOTHER'S MAIDEN NAME: Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 213-14-1406
17. INFORMANT — Address: Mr. Wm. C. Davis, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Generalized arteriosclerosis — 5 years.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 450.0

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Doy, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 7/10 1961, to 9/7 1961, that (I) (~~we~~) last saw the deceased alive on 9/7 1961, and that death occurred at 3:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Frank E. Gantz Jr. M.D.
ATTENDING PHYS. ☒ ~~MED.~~ DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-8-1961
22c. PHYSICIAN'S NAME (Type): Frank E. Gantz Jr. M.D.
22d. ADDRESS: Berlin, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-9-1961
23c. NAME OF CEMETERY OR CREMATORY: Pittsville Cemetery
23d. LOCATION (City, town, or county) (State): Pittsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salsibury, Maryland
25a. REC'D BY REGISTRAR DATE: SEP 11 '61
25b. REGISTRAR'S SIGNATURE: Cathryn L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13 & 14 Film G297 10/11/61 iwk

CERTIFICATE OF DEATH

10808 (Reg. Dist. No.) 10800

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Spring Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizebath; Middle:; Last: Dennis

4. DATE OF DEATH: Month: September; Day: 21; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Col,

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 10, 1862

9. AGE (In years last birthday): 99 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levin Peters

14. MOTHER'S MAIDEN NAME: Elizabeth Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Address R.7 D. 2 Herman Dennis Spring Hill Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yr
DUE TO (b): Arteriosclerosis — Indefinite
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month:; Day:; Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Sept, 19 61 to 21 Sept 19 61, that I last saw the deceased alive on 21 Sept, 19 61 and that death occurred at 6 a.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: Purnell

ADDRESS (Street, city or town, state): 852 W Main Salisbury, Md.

DATE SIGNED: 27 Sept 61

PHYSICIAN'S NAME (Type): E A PURNELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/23/1961

22c. NAME OF CEMETERY OR CREMATORY: Friend Ship

22d. LOCATION (City, town, or county) (State): Allen Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Clinton F. Stewart Salisbury Md

24a. REC'D BY REGISTRAR DATE: SEP 28 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10809 10801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ACCOMAC
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL New Church
d. STREET ADDRESS: 837-2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: E — Last: Dryden

4. DATE OF DEATH: Month: September — Day: 16 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 27, 1889
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): ACCOMAC, VA.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry P. Taylor
14. MOTHER'S MAIDEN NAME: Naomi Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Dryden — Address: New Church

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Shock and Peritonitis	
DUE TO (b)	Perforated Duodenal Ulcer	25 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 16, 1961, to Sept 16, 1961, that (I) (we) last saw the deceased alive on Sept 16 1961, and that death occured at 9:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr., M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/16/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Pine Bluff Road Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/19/61
23c. NAME OF CEMETERY OR CREMATORY: Downings
23d. LOCATION (City, town or county): Oak Hall (State): VA

24. FUNERAL DIRECTOR'S SIGNATURE: W. Fox — ADDRESS: Sempervenille Va.
Fox Funeral Home

25a. REC'D BY REGISTRAR DATE SEP 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10810

CERTIFICATE OF DEATH

10802

1. **PLACE OF DEATH** a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve
c. LENGTH OF STAY IN 1b: 9 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bivalve
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Charles Middle S. Last Duvall

4. **DATE OF DEATH**: Month Sept. Day 7 Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/6/1875

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Duvall

14. MOTHER'S MAIDEN NAME: Johnzna E. Heckel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. **INFORMANT** Address: Mrs Mennie Messick, Bivalve, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

4500

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio sclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 19 61, to Sept. 1 19 61, that (I) (we) last saw the deceased alive on ____ 19 ____, and that death occurred at 1:30 M, from the causes and on the date stated above.

22a. SIGNATURE: Barbara Hunt M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/9/61

22c. PHYSICIAN'S NAME (Type): Barbara Hunt

22d. ADDRESS: Nanticoke, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/9/61

23c. NAME OF CEMETERY OR CREMATORY: Bivalve Cemetery

23d. LOCATION (City, town, or county) (State): Bivalve, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Cobb & Possie ADDRESS: Bivalve, Md.

25a. RECD BY REGISTRAR DATE: SEP 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10811 — 10803

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 135 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   d. STREET ADDRESS: Route # 3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

14 X 2

3. **NAME OF DECEASED** (Type or print): First: William — Middle: David — Last: Elias

4. **DATE OF DEATH**: Month: Sept. — Day: 6 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: oct. 1, 1887

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Daniel Elias

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 214-32-0968

17. INFORMANT: Sarah Lively — Address: Chestertown, Md. — Daughter

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral thrombosis	1 yr
DUE TO (b)	Generalized arteriosclerosis	5 yrs
DUE TO (c)		

330.x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Brain damage - severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 24, 1961 to Sept. 6, 1961, that (I) (we) last saw the deceased alive on Sept. 5, 1961, and that death occured at 7:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/6/61

22c. PHYSICIAN'S NAME (Type): Lee L. Lawry, M. D.

22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/9/61

23c. NAME OF CEMETERY OR CREMATORY: Pomona (Col) Cemetery

23d. LOCATION (City, town or county) (State): nr. Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Dadey

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: SEP 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10812 10804

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Nanticoke
d. STREET ADDRESS: /
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	John	West	Elsey		Sept.	28	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years — last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Colored		6/4/1885	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waterman	Oyster Tonger	Md.	U.S.

13. FATHER'S NAME: George W. Elsey
14. MOTHER'S MAIDEN NAME: Laura Natter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	217-34-3427	Evelyn Elsey	Nanticoke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 14 hours
DUE TO (b): Arteriosclerosis, general and cerebral — ?
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease, decompensated

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 5, 19 61 to Sept. 28, 19 61, that (I) (we) last saw the deceased alive on Sept. 28 19 61, and that death occured at 8:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
V. Juerman			9/28/61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
V. Juerman, M. D.	Deer's Hedd State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	10/1/61	Nanticoke Cem.	Nanticoke, Md.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. M. Bossert	Bivalve, Md.	OCT 2 '61	Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
15M 9/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2 & 7 Firm G297 10/9/61 iwk

10805

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galestown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Granville — Middle: Franklin — Last: Eskridge

4. DATE OF DEATH: Month: 9 — Day: 27 — Year: 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 16, 1906

9. AGE (If years last birthday): ~~54~~ 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: occassional

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Samuel Eskridge

14. MOTHER'S MAIDEN NAME: Lavenia Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Horace J. Eskridge, Laurel, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Tracheo Bronchitis

502.0

DUE TO (b): Pulmonary Emphysema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Days / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

DATE SIGNED: 9-28-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/30/61

22c. NAME OF CEMETERY OR CREMATORY: Galestown Cemetery

22d. LOCATION (City, town, or country) (State): Galestown, Maryland

23. FUNERAL DIRECTOR — ADDRESS: William J Esham Jr Seaford Del

24a. REC'D BY REGISTRAR — DATE: OCT 4 '61

24b. REGISTRAR'S SIGNATURE: Irving S. Towns

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10814 — 10806

1

M

I

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin, Md.
d. STREET ADDRESS: RFD 23X-2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: MARJORIE — Middle: — Last: EVANS

4. DATE OF DEATH: Month: September — Day: 22 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Dec. 18, 1889

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lemuel Clark

14. MOTHER'S MAIDEN NAME: Leah Smack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mr. Howard Evans Berlin, Md. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

4-20.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia (Nephrosclerosis)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/20, 1961, to 9/22, 1961, that (I) (we) last saw the deceased alive on 9/22 19 61, and that death occured at 12 PM, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/24/61

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. Park

23d. LOCATION (City, town or county) (State): Berlin, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: SEP 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

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X

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10815

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10807

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Route # 1.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: Route # 1.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Thomas — Last: Fields

4. DATE OF DEATH: Month: Sept. — Day: 7. — Year: 19 61.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ~~July~~ July 13. 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Builder

11. BIRTHPLACE (State or foreign country): Oxford, Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fields

14. MOTHER'S MAIDEN NAME: Henrietta Fields

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Mrs. Mabel Stewart Fields (Wife) Route # 1. Salisbury, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Dr. Earl L. Royer.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Salisbury, Md. 9-8-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 10.61

22c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery

22d. LOCATION (City, town, or country) (State): Shad Point, Maryland.

23. FUNERAL DIRECTOR: Holloway & Company — ADDRESS: Salisbury, Maryland.

24a. REC'D BY REGISTRAR DATE: SEP 11 '61

24b. REGISTRAR'S SIGNATURE: Caroline S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10816

CERTIFICATE OF DEATH

Item 23 Film G297 10/3/61 mh

10808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 3 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
   a. STATE: Maryland
   b. COUNTY: Somerset ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manokin
   d. STREET ADDRESS: -------
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Nelson — Middle: B. — Last: Fontaine

4. **DATE OF DEATH**: Month: September — Day: 24 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/6/1905

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cuauffer

10b. KIND OF BUSINESS OR INDUSTRY: Taxie

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Isaac Fontaine

14. MOTHER'S MAIDEN NAME: Henrietta Banker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Hospital Records -- Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 Days

332X

DUE TO (b): Recurrent Cerebral Thrombosis — 24 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis, General — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/21/61, 19..., to 9/24/61, 19..., that (I) (we) last saw the deceased alive on 9/24/61 19..., and that death occured at 8A M, from the causes and on the date stated above.

22a. SIGNATURE: V. Juerman M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): V. Juerman, M.D.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/29/61

23c. NAME OF CEMETERY OR CREMATORY: Samuel Wesley

23d. LOCATION (City, town or county) (State): Manokin Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. H. James, Jr., Princess Anne, Md

25a. REC'D BY REGISTRAR DATE: SEP 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10817 10809

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: P.G. Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: Quantico Road Route# 5.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wendy Middle Lynn Last Goslee
4. DATE OF DEATH: Month Sept. Day 6. Year 19 61.
5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (BABY)
8. DATE OF BIRTH: Sept. 6. 1961.
9. AGE (In years last birthday): 0 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): P.G. Hospt. Salisbury, Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Dean H. Goslee
14. MOTHER'S MAIDEN NAME: Nancy Huether
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Dean H. Goslee (Father) Address: Route #5. Salisbury, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis
762.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-6 19 61, to 19, that (I) (we) last saw the deceased alive on 9-6 19 61, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: A C Mitchell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/8/61
22c. PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
22d. ADDRESS: 211 Maryland Ave. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept.9.61.
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery.
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Holloway & Company, Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: SEP 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S Krauss

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G295 9/21/61 iwk

CERTIFICATE OF DEATH

10818 — Reg. Dist. No. 10810

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence prior to admission) — a. STATE: Md — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Md.
d. STREET ADDRESS: 521 Tanzier St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

082

3. NAME OF DECEASED (Type or print): First: Alma — Middle: B. — Last: Hall

4. DATE OF DEATH: Month: September — Day: 12 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 4 1904

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): S Caroline

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles Suter

14. MOTHER'S MAIDEN NAME: Velma Suter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

INFORMANT: Thelma Epps — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(b): Laennec's Cirrhosis — undetermined
(c):

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Laennec's Cirrhosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-10, 1961, to 9-12, 1961, that I last saw the deceased alive on 9-12, 1961, and that death occurred at 2:05 P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: George H. Henning M.D. — Poplar St.

PHYSICIAN'S NAME (Type): George H. HENNING, MD. — Fruitland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9-15-61 — 22c. NAME OF CEMETERY OR CREMATORY: Green Acres Cem — 22d. LOCATION (City, town, or county) (State): Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West — ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 19 '61 — 24b. REGISTRAR'S SIGNATURE: Clifton S. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10819

CERTIFICATE OF DEATH

10811

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

091

19X-2

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 111 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Fairmount
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: — Last: Hall

4. DATE OF DEATH: Month: Sept. — Day: 24 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 19, 1892

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marion Byrd

14. MOTHER'S MAIDEN NAME: Addie Milligian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mr Harry Hall Upper Fairmount, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
420.0
DUE TO (b): Arteriosclerotic heart disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 5, 1961, to Sept. 24, 19 61 that (I) (we) last saw the deceased alive on Sept. 24 19 61, and that death occured at 5:25 P.M, from the causes and on the date stated above.

22a. SIGNATURE: N. Maldve M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/25/61

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 9-27-61

23c. NAME OF CEMETERY OR CREMATORY: Fairmount Cemetery

23d. LOCATION (City, town or county) (State): Fairmount, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Leon Wilson

ADDRESS: Princess Anne, Md.

25a. REC'D BY REGISTRAR DATE: SEP 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10820

10812

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): P.G. Hospt.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
X
d. STREET ADDRESS: 1 Route # 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Pearl	Louise	Harris	Sept.	6.	19 61.

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		April 2. 1924	37 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Worker At	(Pen. Gen. Hospt.)	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clarence Edward Curtis	Bertha Mae Rowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
		Mrs. Bernice Carey (Sister)	Route #5. Salisburym Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instant

692.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Electric Shock Burn

DUE TO (c): Cellulitis Rt. Foot — Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypostatic Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

EXAMINER'S NAME (Type): Dr. Earl L. Royer

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Salisbury, Md.

DATE SIGNED: 7.1961

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	Sept. 9.61.	Mt. Olive Cemetery,	Delmar, Delaware.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Holloway & Company.	Salisbury, Md.	SEP 11 '61	Clinton L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10821

10813

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Wks.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Penisula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Parsonsburg
d. STREET ADDRESS: Ocean City Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES — Middle LAWS — Last HASTINGS

4. DATE OF DEATH: Month 9 — Day 14 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 29, 1885

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William R. Laws

14. MOTHER'S MAIDEN NAME: Mary Edna Betherds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-34-9296

17. INFORMANT: Elmer Hastings — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver disease — INTERVAL BETWEEN ONSET AND DEATH: Week
DUE TO (b): acute cholecystitis — Week
DUE TO (c):

585 X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1 1961 to 9/14 1961 that (I) (we) last saw the deceased alive on 9/14 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Earl M Beardsley M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-16-1961

22c. PHYSICIAN'S NAME (Type): Dr. EARL M. BEARDSLEY M.D.

22d. ADDRESS: Salisbury, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-17-61

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland

25a. REC'D BY REGISTRAR — DATE SEP 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Norman D. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10822

CERTIFICATE OF DEATH

10814

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: since 7/28/61
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pine Bluff State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
d. STREET ADDRESS: FERRY ST 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICE Middle IDA Last HASTINGS

4. DATE OF DEATH: Month Sept. Day 17 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 17, 1886
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Willing
14. MOTHER'S MAIDEN NAME: Lizzie Heath

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: ***
17. INFORMANT Address: Records of Pine Bluff State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
581.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary tuberculosis 002X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/28 1961, to 9/17 1961, that (I) (we) last saw the deceased alive on 9/17 1961, and that death occurred at 7:55 a.m. from the causes and on the date stated above.

22a. SIGNATURE: E.P. Ritchings M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 9/17/61
22c. PHYSICIAN'S NAME (Type): E.P. Ritchings, M.D.
22d. ADDRESS: Pine Bluff State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-19-61
23c. NAME OF CEMETERY OR CREMATORY: TAYLORS
23d. LOCATION (City, town, or county) (State): Sharptown Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Smith Funeral Home, Sharptown, Md

25a. REC'D BY REGISTRAR DATE SEP 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10823 — 10815

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 125 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mardela - Rural
   d. STREET ADDRESS: Route # 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elmira — Middle: Alice — Last: Henry

4. **DATE OF DEATH**: Month: Sept. — Day: 17 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 7, 1876

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Riverton, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Allen

14. MOTHER'S MAIDEN NAME: Harriett Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Alice Hopkins, Mardela Springs, Md., R.F.D.#1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Aspiration of vomitus	6 hrs.
570.3 DUE TO (b)	Volvulus	24 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis with extreme cachexia 002X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 15, 1961, to Sept. 17, 19 61 that (I) (we) last saw the deceased alive on Sept. 17 19 61, and that death occured at 11:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: V. Juerman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 9/18/61

22c. PHYSICIAN'S NAME (Type): V. Juerman, M. D.

22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept.21, 1961

23c. NAME OF CEMETERY OR CREMATORY: Zion Church Cemetery

23d. LOCATION (City, town or county) (State): Near Sharptown, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J.J.Framptom and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE SEP 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10816

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 406 E. Church St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH Middle: FREDRICKA Last: HILYARD
4. DATE OF DEATH: Month: SEPT. Day: 21th Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 12, 1883
9. AGE (In years last birthday) 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilmington, Delaware
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Louis Seidel
14. MOTHER'S MAIDEN NAME: Christina Kern
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mrs. Christine S. Gallo, 1718 Lancaster Avenue, Wilmington, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage Spontaneous — INTERVAL BETWEEN ONSET AND DEATH: 16 days
DUE TO (b): Arterio Sclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Rt hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell at home 406 E. Church St.
20c. TIME OF INJURY Hour: — e.m. p.m. — Month, Day, Year: 8-28 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Salisbury (County) Wicomico (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Dr/Earl L. Royer
Address (Street, city, town, or county): 407 Camden Ave Salisbury, Md
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 22/1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 25, 1961
22c. NAME OF CEMETERY OR CREMATORY: Grace Lawn Mem. Cem.
22d. LOCATION (City, town, or country) (State): Wilmington, Delaware

23. FUNERAL DIRECTOR: ALBERT J. McCrea, Wilmington, Del. — ADDRESS: XXXXXXXXXXXXXXXXXX XXXXXXXXX XXXXXXXX
24a. REC'D BY REGISTRAR DATE: SEP 26 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10825 10817

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 216 Maryland Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 216 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RAYMOND Middle WESLEY Last HOPKINS

4. DATE OF DEATH: Month Sept. Day 19th Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 20,1891
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months 5 Days 29 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shirt Manufacturer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Somerset County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Hopkins
14. MOTHER'S MAIDEN NAME: Ella - - - - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Katharyn Lake-6917 Holabird Ave. Address Baltimore 22, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis.
DUE TO (b): Arteriosclerosis.
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

450.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 9-15 19 to 9-19 1961, that (I) (we) last saw the deceased alive on 9-19 1961, and that death occurred at 3:15 A. M., from the causes and on the date stated above.

22a. SIGNATURE: A C Mitchell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 20 /1961
22c. PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 22, 1961
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: SEP 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10826

CERTIFICATE OF DEATH

Reg. Dist. No. 10819

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Court 2- 1024 Lake St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margorie — Middle: — Last: HUTT

4. DATE OF DEATH: Month: SEPTEMBER — Day: 15 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 15 1961

9. AGE (In years lost birthday): — yrs. IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 3 Min.: 29

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Salisbury md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Hall

14. MOTHER'S MAIDEN NAME: Thelma Hutt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Thelma Hutt. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO
(b): Prematurity
DUE TO
(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 15 19 61, to — 19 —, that I last saw the deceased alive an Sept. 15, 1961, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Morgan M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-16-61

22c. NAME OF CEMETERY OR CREMATORY: Quantico Cem

22d. LOCATION (City, town, or county) (State): Quantico md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker McLeod — ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 19 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/SB

2082334XVO

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10827 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 10818

Items 8 & 9 Film G296 9/26/61 iwk

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eden
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Thomas — Last: James Jr.

4. DATE OF DEATH: Month: 9 — Day: I6 — Year: 19 6I

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/25/1959

9. AGE (In years last birthday): 2 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Eden, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Paul Thomas James, Sr.

14. MOTHER'S MAIDEN NAME: Paul T. James. R F D. Eden, Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Malnutrition

962X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Marked deformities Skull - Left Hand due to Burns

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20e. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Child sustained 3rd degree burns of scalp, hand, ches

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year: 2-29-60

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home.

20f. (City or town) Eden (County) Wicomico (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

DATE SIGNED: 9-17-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/20/6I

22c. NAME OF CEMETERY OR CREMATORY: John Wesley

22d. LOCATION (City, town, or country) (State): Princess Anne, Md

23. FUNERAL DIRECTOR — ADDRESS: William H. James Jr. Princess Anne, Md

24a. REC'D BY REGISTRAR — DATE: SEP 22 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

M

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10828

CERTIFICATE OF DEATH

Reg. Dist. No. 10820

M

I

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: 305 Bay St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Kelly; Last: Jarman

4. DATE OF DEATH: Month: September; Day: 14; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1888

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Berlin, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Kelly

14. MOTHER'S MAIDEN NAME: Ellen Rayne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

INFORMANT: Mr. Clinton A. Jarman, Address: Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — 600.0
DUE TO (b): Hypertensive Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Chronic Pyelonephritis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 10, 1961, to Sept 14, 1961, that I last saw the deceased alive on Sept 14, 1961, and that death occurred at 8 35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hall Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury Md
DATE SIGNED: 9/14/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/15/1961
22c. NAME OF CEMETERY OR CREMATORY: Evergreen
22d. LOCATION (City, town, or county): Berlin (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage
ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: SEP 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G295 9/25/61 iwk

CERTIFICATE OF DEATH

10829

Reg. Dist. No. 10821

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ACCOMAC
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ATLANTIC
d. STREET ADDRESS: R3 X-3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First RICHARD Middle L Last KELLY

4. DATE OF DEATH: Month SEPTEMBER Doy 13 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 21, 1904

9. AGE (In yeors last birthday): 56 YRS. IF UNDER 1 YEAR Months IF UNDER 24 HRS. Doys Haurs Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: SEAFOOD

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arzill Guy Kelley

14. MOTHER'S MAIDEN NAME: Effie C. Kelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 225-40-4609

INFORMANT: Lula Mae Kelley Address: Atlantic, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 7 MONTHS

157X

DUE TO (b) ADENOCARCINOMA PANCREAS — 7 "

Conditions, if any, which gave rise to immediate cause (o), stoting the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that I attended the deceased from 2/28, 1961, to 9/13, 1961, that I last saw the deceased alive on 9/13, 1961, and that death accurred at 11 25 A.M., from the causes and an the date stated abave.

ACTUAL SIGNATURE: John M. Bloxom III M.D. ADDRESS (Street, city or tawn, stote): MEDICAL CENTER DATE SIGNED: 9/16/1961

PHYSICIAN'S NAME (Type): JOHN M. BLOXOM III SALISBURY, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9/16/61

22c. NAME OF CEMETERY OR CREMATORY: GREENWOOD

22d. LOCATION (City, town, or county) (Stote): Temperanceville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: J. P. Fox Jr. ADDRESS: Temperanceville Funeral Home Va.

24a. REC'D BY REGISTRAR DATE: SEP 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10830

10822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Allen
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant — Middle: — Last: King

4. DATE OF DEATH: Month: September — Day: 23 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: SEPTEMBER 23, 1961

9. AGE (If years last birthday): _____ yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 2 — Min: 41

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Salisbury Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Skeffy King

14. MOTHER'S MAIDEN NAME: Barbara Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Skeffy King

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO (b): Premature 1# 5oz
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.: 7735

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: William C. Morgan M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-26-61.

23c. NAME OF CEMETERY OR CREMATORY: Cedar Cem

23d. LOCATION (City, town or county) (State): Allen Md

24 FUNERAL DIRECTOR'S SIGNATURE: Booker McWest

ADDRESS:

25a. REC'D BY REGISTRAR DATE OCT 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

20 82.194 XVO

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10831 10823

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deers Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23-2

091

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Handy	Latchum	9-22-61		19

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W		1874	87 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Farmer	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John William Latchum	~~Jenny Tarkle~~ Kate Hearn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
XX	XX	XX	George Latchum Berlin, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Fracture of Base of Skull
DUE TO (c):

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Instant / 5 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Ran through red light and hit another car-Rt.113x50

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
1:30 a.m. P.M. 8-15-61		Highway	Berlin Worcester Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9-24-61

EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	9/25/61	I. O. O. F.	Bishopville, Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Peter Whaley Salisbury, Md.	SEP 28 '61	Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10832 Items 7, 8 & 9 Film G297 10/2/61 mh 10824

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge 0913-2
d. STREET ADDRESS: 201 Willis St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Otis; Middle: Carrol; Last: LeCompte

4. DATE OF DEATH: Month: Sept. Day: 24 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 8, 1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Huckster

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Dorchester County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Caleb LeCompte

14. MOTHER'S MAIDEN NAME: Mary Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-10-8384

17. INFORMANT: Address: Mrs. Beulah LeCompte Wilmington Del.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary vessel occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(b): Generalized arteriosclerosis — 5 years
DUE TO
(c):

42011
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ca. of the larynx, operated in 1957.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 11, 1961, to Sept. 24, 1961 that (I) (we) last saw the deceased alive on Sept. 24, 1961, and that death occured at 7:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lee L. Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/25/61

22c. PHYSICIAN'S NAME (Type): Lee L. Lawry, M. D.

22d. ADDRESS: Deer's Head State Hospital Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 27, 1961

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City, town or county) (State): Cambridge, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: LeCompte Funeral Service

ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: SEP 27 '61

25b. REGISTRAR'S SIGNATURE: Elmer L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10825

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PEN. GEN. HOSPT.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 192A Ocean City Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): James Harry Littleton
4. DATE OF DEATH: Month: Sept. Day: 3. Year: 1961.

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 12.1926
9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: (Southern States Petroleum Coop.)
11. BIRTHPLACE (State or foreign country): Parksley, Va. (U.S.A.)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dorsey Littleton
14. MOTHER'S MAIDEN NAME: Emma Dix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
16. SOCIAL SECURITY NO. (If yes give war or dates of service): W.W. # 2.
17. INFORMANT (Address): Mrs. Jean Littleton (Wife) 192A Ocean City Road, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rupture of Liver, Bowel + Bladder — 16 hours
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Auto Accident

20c. TIME OF INJURY: Hour 10 a.m. p.m. Month, Day, Year: 9-2 1961
20d. INJURY OCCURRED While at work ☑ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Dr. Earl L. Royer
Address (Street, city, town, or county): 407 Camden, Ave. Salisbury, Md.
DATE SIGNED: 5/1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 6.61
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or country) (State): Salisbury, Md.

23. FUNERAL DIRECTOR: Holloway & Co. ADDRESS: Salisbury, Maryland.
24a. REC'D BY REGISTRAR DATE: SEP 8 '61
24b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10826

10834

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 619 Railroad Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 619 Railroad Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MILLIE Middle JANE Last MADDOX

4. DATE OF DEATH: Month SEPT. Day 25th Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 11, 1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Wango R.D.#Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: (Unk)
14. MOTHER'S MAIDEN NAME: Sarah Jane Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Maude A. Smith (Daughter) Address: 619 Railroad Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis.
DUE TO (b): Senility
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to ____ 19__, that (I) (we) last saw the deceased alive on 9-25 1961, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 27 1961
22c. PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 27, 1961
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: SEP 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10835 . **CERTIFICATE OF DEATH** 10827

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 90 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporeta limits, write RURAL and give nearest town): X Salisbury
   d. STREET ADDRESS: Jenkins Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Typa or print): First: William — Middle: Benjamin — Last: Marvel

4. **DATE OF DEATH**: Month: Sept. — Day: 5 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9. 1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, aven if retirad): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Marvel

14. MOTHER'S MAIDEN NAME: Elizabeth Hearn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Name, Address): Mrs. Madelyn Miles (Neice) 107 E. Locust St. Salisbury, Maryland.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral thrombosis	2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	023X Luetic endarteritis	10 yrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congenital cleft palate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 7, 1961, to Sept. 5, 1961, that (I) (we) last saw the deceased alive on Sept. 4 1961, and that death occured at 1:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/5/61

22c. PHYSICIAN'S NAME (Type): Lee L. Lawry, M.D.

22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: Sept. 7.61

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery,

23d. LOCATION (City, town or county) (State): Salisbury, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: Holloway & Co. — ADDRESS: Salisbury, Maryland.

25a. REC'D BY REGISTRAR DATE SEP 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18 to 21, Film G-297 10/17/61. cec. 10828

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 711 Camden Ave (Office)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 311 Newton St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DR. HARRY — Middle: McCOY — Last: MATTAX

4. DATE OF DEATH: Month: SEPT. — Day: 15th — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct.5,1924

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months: 11 — Days: 10
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician - Doctor

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Harry A.Mattax

14. MOTHER'S MAIDEN NAME: Elizabeth Jane Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Mrs.Alberta M.Mattax(Wife)311 Newton St Salisbury,Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Demorol Poisoning — INTERVAL BETWEEN ONSET AND DEATH: hours

970.8

DUE TO (b):

Conditions, if any, which gave risa to immediate cause (e), stating the underlying causa last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Self inflicted with syringe

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 9/ 15 19 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Office

20f. (City or town) (County) (State): Salisbury(Wicomico) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr.Earl L.Royer
Address (Street, city, town, or county): 407 Camden Ave.Salisbury,Md

DATE SIGNED: Sept. 15 /1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept.16,1961
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or country) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY - SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: SEP 19 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10831

TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Route # 4 (Wango)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Route # 4 (Wango)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lloyd — Middle: Washington — Last: Mitchell

4. DATE OF DEATH: Month: 9 — Day: 22 — Year: 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 12-24-1903

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Wicomico County, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry W. Mitchell

14. MOTHER'S MAIDEN NAME: Mary A. Townsend

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unk

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Daughter: Mrs. Dorothy Cooper 808 S. Division St. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: Weeks

159X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): G. I. malignancy — 1 year.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: a) Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 107 Camden Ave. Salisbury, Md.

DATE SIGNED: 9-23-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 25/61

22c. NAME OF CEMETERY OR CREMATORY: Wango Church Cemetery

22d. LOCATION (City, town, or country) (State): R.D.#Salisbury, Maryland

23. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR — DATE: SEP 25 '61

24b. REGISTRAR'S SIGNATURE: Cathryn S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G295 9/21/61 iwk

CERTIFICATE OF DEATH

10837 Reg. Dist. No. 10829

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 716 N Westover Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ethel Middle Lost McBride

4. DATE OF DEATH Month September Day 11 Year 1961

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 7-23-1922

9. AGE (In years last birthday) 39 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Maid.

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Salisbury Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME Ethel Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 216-11-9489

INFORMANT Ethel Hudson Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis generalized. — INTERVAL BETWEEN ONSET AND DEATH 1 Day

DUE TO (b) Intestinal perforation — 8 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Distension ? Post Op. — 3 days

578X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/7, 1961, to 9/11, 1961, that I last saw the deceased alive on 9/11, 1961, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm B Smith M.D. ADDRESS (Street, city or town, state) Med. Center Sby Md. DATE SIGNED 9/12/61.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 9-16-61

22c. NAME OF CEMETERY OR CREMATORY Green Acres Cem

22d. LOCATION (City, town, or county) Salisbury (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Booker & West ADDRESS

24a. REC'D BY REGISTRAR DATE SEP 19 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10838 Item 9 Film G297 10/16/61 lwk 10830

1. PLACE OF DEATH
e. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Ross Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23 X 2

3. NAME OF DECEASED (Type or print): First: Robert Middle: James Last: Miles, Jr.

4. DATE OF DEATH: Month: 9-22-61 Day: Year: 19

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-12-23

9. AGE (In years last birthday): 37 39 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Miles Sr.

14. MOTHER'S MAIDEN NAME: Mary E. Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mary Coplain Snow Hill Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bullet Wound of Brain — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

981X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot during a quarrel at 14 Twilley Circle, Sal. Md.

20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year: 9:30 P.M. 9-22-61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

DATE SIGNED: 9-24-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/28/1961

22c. NAME OF CEMETERY OR CREMATORY: Baptis

22d. LOCATION (City, town, or country) (State): Snow Hill Md.

23. FUNERAL DIRECTOR: Clinton F. Stewart

ADDRESS: Salisbury Md

24e. REC'D BY REGISTRAR DATE: OCT 3 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10840

CERTIFICATE OF DEATH

10832

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1018 Marion St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LYNDA — Middle: - — Last: Moore

4. DATE OF DEATH: Month: September — Day: 18 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 16, 1961

9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months: 0 — Days: 2 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Raymond Lee Moore

14. MOTHER'S MAIDEN NAME: Mildred Patricia Sturgis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Father — Address: 1018 Marion St Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH:
762.5
DUE TO (b): atelectasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: e.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/16, 1961, to 9/18, 1961, that (I) (we) last saw the deceased alive on 9/18 1961, and that death occured at 4:45 A.M, from the causes and on the date stated above.

22a. SIGNATURE: William C. Morgan M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/18/61

22c. PHYSICIAN'S NAME (Type): Dr. William C. Morgan

22d. ADDRESS: Medical Center Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-19-61

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Memory Gardens

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2082334 X V2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10841 — item 8 Film G297 10/4/61 jsk — 10833

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STOCKTON Md 19X-2
d. STREET ADDRESS: Box 121 C/o P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: HARRY — Middle: — Last: PALMER

4. DATE OF DEATH: Month: SEPTEMBER — Day: 18 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: MAR. 1892/1893

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: SEA FOOD

11. BIRTHPLACE (County & State, or foreign country): STOCKTON Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: NATHAN PALMER

14. MOTHER'S MAIDEN NAME: BARBARA ANN MANUEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES

16. SOCIAL SECURITY NO.: 217307700

17. INFORMANT: MARIE JONES — Address: STOCKTON Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: Undetermined

DUE TO (b): Arterio Sclerosis — Undefinite

DUE TO (c):

451 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED: While at work ☐ Not While at work ☐

2Da. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 15 Sept, 1961 to 18 Sept, 1961 that (I) (we) last saw the deceased alive on 18 Sept 19 61 and that death occured at 12 M., from the causes and on the date stated above.

22a. SIGNATURE: C Burnell, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 18 Sept 61

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: SEPT 23, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: HOME BENIFICIAL CEM — 23d. LOCATION (City, town or county) (State): STOCKTON Md

24. FUNERAL DIRECTOR'S SIGNATURE: Anthony E. Ward — ADDRESS: 11354th St. Crisfield Md.

25a. REC'D BY REGISTRAR DATE: SEP 20 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10842

CERTIFICATE OF DEATH

10834

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: Box# 6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JOHN — Middle FRANK — Last PARKER

4. **DATE OF DEATH**: Month SEPT. — Day 17th — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 3, 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months — Days — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Bishopville, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Abb Parker

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. James A. Parker (Son) Address: Box#6 Parsonsburg Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
157X
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year: N/A 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A

20f. (City or town) (County) (State): N/A

21. **I certify** that (I) (this hospital) attended the deceased from 6- 1957 to 9-17 1961, that (I) (we) last saw the deceased alive on 9-17 1961, and that death occurred at 4:40A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wilbur R. Ellis Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 18, 1961

22c. PHYSICIAN'S NAME (Type): Dr. Wilbur R. Ellis Jr.

22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-19-61

23c. NAME OF CEMETERY OR CREMATORY: Parsonsburg Cemetery

23d. LOCATION (City, town, or county) (State): Parsonsburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

25a. REC'D BY REGISTRAR DATE: SEP 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10835

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 309 Happy Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Henry — Last: Pinkett
4. DATE OF DEATH: Month: 9 — Day: 20 — Year: 61 (19)
5. SEX: M
6. COLOR OR RACE: AA
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 10, 1867
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Seafood
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Pinkett
14. MOTHER'S MAIDEN NAME: Mary Nearn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Ethel Pinkett, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Arterio Sclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332 X
INTERVAL BETWEEN ONSET AND DEATH: 3 days / years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell down stairs at home.
20c. TIME OF INJURY — Hour a.m.: 12 Noon — Month, Day, Year: 9-17-61
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home.
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9-24-61
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-24-61
22c. NAME OF CEMETERY OR CREMATORY: Green Acre Cem.
22d. LOCATION (City, town, or country) (State): Salisbury, Md.

23. FUNERAL DIRECTOR — ADDRESS: Thornton B. Jolley, Salisbury, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 28 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10844 — Reg. Dist. No. 10836

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: 19X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Edward — Last: Pollitt

4. DATE OF DEATH: Month: Sept. — Day: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 8 1905

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chicken Grower
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Pollitt

14. MOTHER'S MAIDEN NAME: Fannie LeCates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: Robert Pollitt — Address: Princess Anne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure + Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Hypertensive Cardiovascular Disease

DUE TO (c): Chronic Glomerulonephritis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

593X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1961, to Sept 14, 1961, that I last saw the deceased alive on Sept 14, 1961, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md — DATE SIGNED: 9/14/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept 17, 1961 — 22c. NAME OF CEMETERY OR CREMATORY: Manokin — 22d. LOCATION (City, town, or County) (State): Princess Anne

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest Hummer — ADDRESS: Princess Anne

24a. REC'D BY REGISTRAR DATE: SEP 20 '61 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10845

CERTIFICATE OF DEATH

10837

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 3Yrs.9Mos.29Da.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Parsonsburg
   d. STREET ADDRESS: ------
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Laura — Middle: ----- — Last: Porter

4. **DATE OF DEATH**: Month: September — Day: 2 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 21, 1871

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___

IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (County & State, or foreign country): Worcester, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James H. Porter

14. MOTHER'S MAIDEN NAME: Isabelle Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give wer or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records -- Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), end (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b): Arteriosclerosis, General — Years

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/4/57, 19..., to 9/2/61, 19..., that (I) (we) last saw the deceased alive on 9/2/61 19..., and that death occured at 8P.M. from the causes and on the date stated above.

22a. SIGNATURE: V. Juerman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): V. Juerman, M.D.

22d. ADDRESS: Deer's Head State Hospital - Salisbury

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-4-61

23c. NAME OF CEMETERY: Holy Cross Episcopal

23d. LOCATION (City, town or county) (State): Stockton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson

ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

L. Summers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10845

CERTIFICATE OF DEATH

Reg. Dist. No. 10838

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury
d. STREET ADDRESS 117 Washington Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First — Middle — Last: Radford
4. DATE OF DEATH Month: 9 Day: 7 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 7. 61.
9. AGE (In years last birthday) — yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 19 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): P.G. Hospt. Salisbury, Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willie Lee Radford
14. MOTHER'S MAIDEN NAME: Joyce Ann Ray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Mr. Willie Lee Radford (Father) Address: 117 Washington, St. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency
754.4
DUE TO (b) Congenital Cardiac defect.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/7, 1961, to 9/7, 1961, that I last saw the deceased alive on 9/7, 1961, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm B Smith M.D. ADDRESS (Street, city or town, state): Med. Center Salisbury, Md. DATE SIGNED: 9/7/61
PHYSICIAN'S NAME (Type): Dr. Wm, B. Smith Med. Center, Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 11. 61.
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cem.
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Holloway & Co. Salisbury, Maryland.
24a. REC'D BY REGISTRAR DATE: SEP 11 '61
24b. REGISTRAR'S SIGNATURE: Lindsay E. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

2082.261XV3

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10847

CERTIFICATE OF DEATH

10839

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 606 E. Isabella St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 606 E. Isabella St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALMA — Middle CLARA — Last ROBERTSON

4. DATE OF DEATH: Month SEPT. — Day 22 — Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1893
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin Parker
14. MOTHER'S MAIDEN NAME: Martha - Nancy Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Marie Bailey (Daughter) Address: 606 E. Isabella St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage.
DUE TO (b): Hypertension & Arteriosclerosis
DUE TO (c): Diabetes Mellitus

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m.: N/A 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 9/2/61, 19, to 9/22/61, 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Carrie Hearn M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 23 /1961
22c. PHYSICIAN'S NAME (Type): Dr. Carrie I Hearn
22d. ADDRESS: N. Division St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept 24/61
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: SEP 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10848

CERTIFICATE OF DEATH

10840

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARDELA
c. LENGTH OF STAY IN 1b: 70 YRS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MAPLE SHADE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SHARPTOWN
d. STREET ADDRESS: 1 MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Oscar; Middle: H.; Last: RUSSELL

4. DATE OF DEATH: Month: Sept; Day: 26; Year: 19 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT 23, 1875

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR — Months: ; Days: ; IF UNDER 24 HRS. — Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: ALGERNON RUSSELL

14. MOTHER'S MAIDEN NAME: ARCADIA GRAVENOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: MRS J DORSEY — Address: 3707 ADAMS MILL RD BASSETT WASHINGTON DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra abdominal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Carcinoma of stomach — 2 yrs
DUE TO
(c):

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5 Sept 19 61 to 26 Sept 19 61, that (I) (~~not~~) last saw the deceased alive on 26 Sept 19 61, and that death occurred at 6 A.M. from the causes and on the date stated above.

22a. SIGNATURE: M. D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 29 Sept 61

22c. PHYSICIAN'S NAME (Type): George G. Schlesinger — 22d. ADDRESS: Box 151 Mardela - Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 9-30-61 — 23c. NAME OF CEMETERY OR CREMATORY: FIREMENS — 23d. LOCATION (City, town, or county) (State): SHARPTOWN, MD

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: SMITH FUNERAL HOME, SHARPTOWN, MD

25a. REC'D BY REGISTRAR — DATE: OCT 6 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10849 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 10841

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Ocean City 23X-2
d. STREET ADDRESS: Harbor Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Selby — Last: Shuman

4. DATE OF DEATH: Month, Day, Year: 9-13-61 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG. 27, 1866

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): BISHOPVILLE MD

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: MILBY BUNTING

14. MOTHER'S MAIDEN NAME: MARY LAYTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: Address: MRS. ALICE SPENCER, OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral contusions — INTERVAL BETWEEN ONSET AND DEATH: 11 days
9000
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell down five steps at own home.

20c. TIME OF INJURY: Hour, a.m. 4:50 A.M. Month, Day, Year: 9-2-61

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own Home

20f. (City or town) (County) (State): W. Ocean City Worcester Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
DATE SIGNED: 9-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/18/61
22c. NAME OF CEMETERY OR CREMATORY: TAYLORVILLE
22d. LOCATION (City, town, or county) (State): BERLIN, MD. R.F.D.

23. FUNERAL DIRECTOR: Anna A. Bunbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: SEP 20 '61

24b. REGISTRAR'S SIGNATURE: O Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10850 — Registered No. 10842

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill — 23X-2
d. STREET ADDRESS: 300 S. Bay St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Guston — Middle: L. — Last: Sick

4. DATE OF DEATH: Month: SEPTEMBER — Day: 5 — Year: 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 13 — 1881
9. AGE (In years last birthday): 80 yrs. 7 mos.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: own Farm
11. BIRTHPLACE (State or foreign country): Madgeburg, Germany
12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mr Louis L. Dick — Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Arteriosclerotic Gangrene of Lg
DUE TO (c): Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.1
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1, 1961, to 9/5, 1961, that I last saw the deceased alive on 9/5, 1961, and that death occurred at 12:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William H. Fisher, M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: 9-6-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 7 '61
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elliott & Timms — ADDRESS: Snow Hill, Md
24a. REC'D BY REGISTRAR DATE: SEP 11 '61
24b. REGISTRAR'S SIGNATURE: Elliott & Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G297 10/3/61 mh

CERTIFICATE OF DEATH

10851 — Reg. Dist. No. 1084.5

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 15 Patrick Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 15 Patrick Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle W. — Last Smiley

4. DATE OF DEATH: Month September — Day 17 — Year 1961

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1878 — May 5. ~~1961~~ 1871

9. AGE (In years lost birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Hester ~~Han~~ Smiley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: alice purnell Address: 16 patrick ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b): Arteriosclerosis — Indefinite
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 Sept., 19 61 to 17 Sept., 19 61, that I last saw the deceased alive on 17 Sept., 19 61, and that death occurred at 5 P. M. from the causes and an the date stated abave.

ACTUAL SIGNATURE: E. A. Purnell, M.D. — ADDRESS (Street, city or town, state): 65 W Main Salisbury, Md — DATE SIGNED: 27 Sept 61

PHYSICIAN'S NAME (Type): E. A. Purnell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/22/ 1961

22c. NAME OF CEMETERY OR CREMATORY: Green Acres

22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Clinton F. Stewart Salisbury Md

24a. REC'D BY REGISTRAR — DATE: SEP 28 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10852

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10844

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
   d. STREET ADDRESS: Route # 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: ; Last: Smith

4. DATE OF DEATH: Month: 9-7-61; Day: ; Year: 19

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 1, 1889

9. AGE (In years last birthday): 72 yrs.
   IF UNDER 1 YEAR: Months: ; Days:
   IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pocomoke, Worcester, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Suther Smith

14. MOTHER'S MAIDEN NAME: Polly Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mary Pittman; Address: Pocomoke, Worcester, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Degeneration	
DUE TO (b)	Arterio Sclerotic	
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑ Inspection ☑ Inquiry ☑ and in my opinion death resulted from: Natural causes ☑ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royster M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county): 101 Camden Ave. Salisbury, Md.

DATE SIGNED: 9-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEP, 10-61

22c. NAME OF CEMETERY OR CREMATORY: CHRIST M.E.

22d. LOCATION (City, town, or country) (State): POCOMOKE, WOR. MD.

23. FUNERAL DIRECTOR: Charles H. Ward; ADDRESS: Mason Md

24a. REC'D BY REGISTRAR DATE: SEP 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10853

CERTIFICATE OF DEATH

10845

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 44 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henderson
d. STREET ADDRESS: None 05X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Charles	H.	Thorpe		Sept.	8	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		1-21-1896	65 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laboror	None	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Thorpe	Lizzie Seward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	222-05-3813	Charles Thorpe Jr. Henderson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 month
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. / Month, Dey, Yeer 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from July 26, 1961 to Sept. 8, 1961, that (I) (we) last saw the deceased alive on Sept. 8, 1961, and that death occured at 1 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Sept. 8, 1961
22c. PHYSICIAN'S NAME (Type): LEE L. LAWRY, M. D.
22d. ADDRESS: Deer's Head State Hospital Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	9-11-61	Templeville	Templeville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. E. Boulois Greensboro, Md.	SEP 11 '61	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10854 10846

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Wicomico
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b: yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, i.e., normal residence before admission)
a. STATE: md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rose St. apt (4)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur Middle: Last: Townsend

4. DATE OF DEATH: Month: Sept Day: 7 Year: 1961

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-15-13

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Del

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Townsend

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 221-10-6572

17. INFORMANT: Elizabeth Townsend Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Ryan M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-12-61

22c. NAME OF CEMETERY OR CREMATORY: Massey Cem

22d. LOCATION (City, town, or country) (State): Smyrna Del

23. FUNERAL DIRECTOR: Parker McWest ADDRESS:

24a. REC'D BY REGISTRAR: SEP 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

1

FOR STATE HEALTH DEPT.

M

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2

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2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10847

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 23 x 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: — Last: Tyndall

4. DATE OF DEATH: Month: 9 — Day: 24 — Year: 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 8, 1882

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Tyndall

14. MOTHER'S MAIDEN NAME: Elizabeth Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Bertha Cherrix Tyndall Snow Hill

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage
DUE TO (b): Rupture of Spleen
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 hours / 2 days

903.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Myelocytic Leukemia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Fell at home and struck left lower chest on chair.

20c. TIME OF INJURY — Hour: a.m. / p.m. — Month, Day, Year: 9-22-1961

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home.

20f. (City or town) (County) (State): Snow Hill Worcester Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9-25-61

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 27, 1961

22c. NAME OF CEMETERY OR CREMATORY: Downing Cemetery

22d. LOCATION (City, town, or country) (State): Oak Hall, Virginia

23. FUNERAL DIRECTOR — ADDRESS: Salyer Funeral Home, Chincoteague, Virginia

24a. REC'D BY REGISTRAR (DATE): SEP 27 61

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10856 10848

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Ross St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: E. — Last: Victor

4. DATE OF DEATH: Month: September — Day: 26 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: January 23, 1912

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel H. Johnson

14. MOTHER'S MAIDEN NAME: Annie Hutt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Son Victor Ross St. Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral Basler Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): Post operative diffuse Peritonitis — ? 18 days.

DUE TO (c): Hysterectomy and bilateral oopherectomy — 18 days.

633X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from ..... 19..... to 26 Sept ....., 1961, that (I) (~~me~~) last saw the deceased alive on Sept. 26 19 61, and that death occured at 10:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D.

22b. DATE SIGNED: 9/28/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Pine Bluff Rd. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/30/1961

23c. NAME OF CEMETERY OR CREMATORY: Cool Spring

23d. LOCATION (City, town or county) (State): Girdletree Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Clinton F. Stewart Salisbury Md

25a. REC'D BY REGISTRAR DATE OCT 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] ay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10857 10849

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Eden
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Route # 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eden
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mathew	Champion	Wallace	9-12-61		19

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	AA		8-17-61			25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Mathew Wallace	Daisey Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Mathew Wallace, father, Eden, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden.
DUE TO (b):
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
9240

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Infant sleeping in bed with mother and found dead.

20c. TIME OF INJURY Hour a.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work X	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
6 A.M.	9-12-61		Own home	Wicomico Eden, Md.		

21. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
DATE SIGNED: 9-17-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	9-14-61	Mt Calvary Cem.	Fruitland, Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Thornton B. Jolley, Salisbury, Md	SEP 21 '61	Arthur S. Travers

2082244XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G297 10/4/61 1wk

CERTIFICATE OF DEATH

10858

Reg. Dist. No. 108.50

1

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Sharptown Md. b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown
d. STREET ADDRESS Laurel Sharptown Hyway
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First: Elizabeth Middle: Ellen Last: Waller

4. DATE OF DEATH Month: SEPT Day: 1 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 27, 1892
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Perry O. Waller
14. MOTHER'S MAIDEN NAME: Elnora Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Mrs Fred Massey Address: Sharptown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal carcinomatosis Due to
DUE TO (b): Carcinoma of the pancreas
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
157
INTERVAL BETWEEN ONSET AND DEATH: 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-20, 1961, to 9-1, 1961, that I last saw the deceased olive on 9-1, 1961, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H Fisher M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: 9-1-61
PHYSICIAN'S NAME (Type): WILLIAM H FISHER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-4-61
22c. NAME OF CEMETERY OR CREMATORY: Fikemens
22d. LOCATION (City, town, or county) (State): Sharptown MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Smith Funeral Home Sharptown Md

24a. REC'D BY REGISTRAR DATE: SEP 6 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10859

CERTIFICATE OF DEATH

10851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 413 Pactric Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: — Last: Waller

4. **DATE OF DEATH**: Month: September — Day: 25 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 8, 1899

9. AGE (If years last birthday): 62 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lowis Waller

14. MOTHER'S MAIDEN NAME: Edith Dashiell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Louise Waller 413 patrick ave — Address: Salisbury Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
4221
Conditions, if any, which gave rise to Immediate cause (e), stating the underlying cause last.
DUE TO (b): Ascuhd. — 2years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-19, 1961, to 9-25, 1961, that (I) (we) last saw the deceased alive on 9-25 1961, and that death occured at 9:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Hans R. Wilhelmsen M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9-26-61

22c. PHYSICIAN'S NAME (Type): HANS R. Wilhelmsen

22d. ADDRESS: Peninsula General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/30/1961

23c. NAME OF CEMETERY OR CREMATORY: Green Acres

23d. LOCATION (City, town or county) (State): Salisbury Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart — ADDRESS: Salisbury Md.

25a. REC'D BY REGISTRAR DATE: OCT 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10860 10852

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 13 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 831 S.Div. St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle WASHINGTON — Last WEAVER

4. DATE OF DEATH: Month 9 — Day 23 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb.2,1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Guard U.S. Navy Department

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Wm. Weaver

14. MOTHER'S MAIDEN NAME: Amanda Jane Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes (1903-09) 1909-13

16. SOCIAL SECURITY NO.: 216-10-7760

17. INFORMANT — Address: Mrs Hilda Irene Weaver, Same

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Embolism — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Diabetes Mellitus Coronary Arteriosclerosis
DUE TO (c): Diabetes Mellitus

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that (I) (this hospital) attended the deceased from June 1, 1961, to 9-23, 1961, that (I) (we) last saw the deceased alive on 9-23 1961, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Carrie Hearn — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9-23-1961

22c. PHYSICIAN'S NAME (Type): CARRIE HEARN.

22d. ADDRESS: 226 N. Division St

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-27-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cemetery

23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur B. Kraus

Hill & Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10861 — 10853 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chance
d. STREET ADDRESS: Main Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALLEN Middle Whitelock Last

4. DATE OF DEATH: Month September Day 4 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 31-1908
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Seafood
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LAFAYETTE WHITELOCK
14. MOTHER'S MAIDEN NAME: OLIVE ARMIGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): April 1941 to Aug 1945
16. SOCIAL SECURITY NO.:

INFORMANT: EVELYN WHITELOCK — Address: Chance Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-4, 1961, to 9-4, 1961, that I last saw the deceased alive on 9-4, 1961, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Elliott M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 9-4-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 6-1961
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek M.E.
22d. LOCATION (City, town, or county) (State): Chance Md.

23. FUNERAL DIRECTOR'S SIGNATURE: L. G. Webster — ADDRESS: Princess Anne Md.
24a. REC'D BY REGISTRAR DATE: SEP 6 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10862 10854

CERTIFICATE OF DEATH

Item 8 Film G295 9/21/61 iwk

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Eden
c. LENGTH OF STAY IN 1b: Allher life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Route #2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Ann — Last: Whitney

4. DATE OF DEATH: Month: 9 — Day: 3 — Year: 19 61

5. SEX: FM

6. COLOR OR RACE: AA

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12 1 1888/1878

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin Peters

14. MOTHER'S MAIDEN NAME: Otelia Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NN

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Lora Jones, Eden, Md., Rt #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac degeneration ~~Arterio sclerotic Coronary Thrombosis~~

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

422.2

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 5-26 19 56 to 19, that (I) (we) last saw the deceased alive on 6-5 19 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: A C Mitchell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/8/61

22c. PHYSICIAN'S NAME (Type): Andrew C. Mitchell, MD

22d. ADDRESS: 211 Maryland Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9 9 61

23c. NAME OF CEMETERY OR CREMATORY: Friendship Cem.

23d. LOCATION (City, town or county) (State): Allen, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Thernton B. Jolley, Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: SEP 13 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10863

CERTIFICATE OF DEATH

Item 9 Film G297 10/2/61 mh

10855

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: 23 x 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: WILLIAMS

4. DATE OF DEATH: Month: SEPTEMBER — Day: 20 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: September 19, 1961

9. AGE (In years last birthday) ___ yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 11 / Min.: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (County & State, or foreign country): Wicomico; Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Williams

14. MOTHER'S MAIDEN NAME: Essie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Samuel Williams Pocomoke City Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
760.0

INTERVAL BETWEEN ONSET AND DEATH: appox 12 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/19 1961, to 9/20, 1961, that (I) (we) last saw the deceased alive on 9/20 1961; and that death occured at 9:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Alfred C Kolb M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/29/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-21-61

23c. NAME OF CEMETERY OR CREMATORY: Wharton Memorial Cem.

23d. LOCATION (City, town or county) (State): Parksley, Va.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Samuel Lowgel, Keinchurch Va.

25a. REC'D BY REGISTRAR — DATE: SEP 28 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Evans

2082348XV8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10864

CERTIFICATE OF DEATH

10856

1 (M) (I) (O)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress): 336 Delaware Ave.,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town): 12 Salisbury
d. STREET ADDRESS: 336 Delaware Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charlie — Middle: — Last: Williams

4. DATE OF DEATH: Month: 9 — Dey: 25 — Year: 19 61

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 12/17/1890

9. AGE (In yeers last birthday): 70 s.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Bldg.

11. BIRTHPLACE (County & State, or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Elinor Weedley, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Probable Coronary Disease — Unk
DUE TO (c): Hypertension — Unk

420.1

Conditions, if eny, which gave rise to immediate cause (a), stating the underlying ceuse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 25, 1961, to Sept. 25, 1961, that (I) (~~me~~) last saw the deceased alive on Sept. 25, 1961, and that death occured 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/27/61

22c. PHYSICIAN'S NAME (Type): G. Herbert Sembly, M.D.

22d. ADDRESS: 400 E. Church St., Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/30/61

23c. NAME OF CEMETERY OR CREMATORY: Green Acre Cem.

23d. LOCATION (City, town or county) (State): Salisbury, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Thornton B. Jolley, Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: OCT 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10865 Item 9 Film G295 9/21/61 lwk 10857

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Delmar
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: D.O.A. at Pen Gen Hospital	d. STREET ADDRESS: R.D.# 3 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: DANIEL	Middle: EDGAR	Last: WILLIAMS	4. DATE OF DEATH	Month: SEPT.	Day: 14th	Year: 1961	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Sept. 15, 1899	9. AGE (In years last birthday): 61 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant-Grocer	10b. KIND OF BUSINESS OR INDUSTRY: Store	11. BIRTHPLACE (State or foreign country): Allen, Maryland	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: James Wesley Williams		14. MOTHER'S MAIDEN NAME: Sarah Jane Ryall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Louise E. Williams (Wife) Address: R.D.# 3 Salisbury, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year: N/A 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) N/A	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from _____ 19__ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 3:50P M. from the causes and on the date stated above.

22a. SIGNATURE: William H Fisher Jr M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: Sept. 15/1961	
22c. PHYSICIAN'S NAME (Type): Dr. William H. Fisher Jr	22d. ADDRESS: Medical Center Salisbury, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Sept. 17, 1961	23c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery	23d. LOCATION (City, town, or county) (State): R.D.# Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE: HOLL WAY & COMPANY	ADDRESS: SALISBURY MARYLAND	25a. REC'D BY REGISTRAR DATE: SEP 19 '61	25b. REGISTRAR'S SIGNATURE: Arthur L. Travers	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10866

CERTIFICATE OF DEATH

Reg. Dist. No. 10858

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Md
d. STREET ADDRESS: 705 Westover Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stephanie Middle: A. Last: Wilson

4. DATE OF DEATH: Month: September Day: 3 Year: 1961

5. SEX: Female
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 2, 1961
9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months: 1 Days: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Raymond Wilson
14. MOTHER'S MAIDEN NAME: Elizabeth Briddell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

INFORMANT: Raymond Wilson
Address: Salisbury Md. 705 W. Westover Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peripheral Vascular Collapse
DUE TO (b): Dehydration and Acidosis
DUE TO (c): Gastroenteritis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Appox 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/3, 19 61, to 9/3, 19 61, that I last saw the deceased alive on 9/3, 19 61, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C Kolli M.D.
ADDRESS (Street, city or town, state): Medical Center Salisbury, Maryland
DATE SIGNED: 9/3/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/6/1961
22c. NAME OF CEMETERY OR CREMATORY: Green acres
22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart
ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE: SEP 13 '61
24b. REGISTRAR'S SIGNATURE: Carlton S. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2082202 x V4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10867 10859

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
   c. LENGTH OF STAY IN 1b: 40 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 501 Elizabeth Street

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
   d. STREET ADDRESS: 501 Elizabeth Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: WALTER — Middle: THOMAS — Last: WORKMAN

4. **DATE OF DEATH**: Month: Sept. — Day: 14th — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 11, 1888

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elijah Workman

14. MOTHER'S MAIDEN NAME: Ella Truitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): ---------221-12-8446

17. INFORMANT — Address: Rowena Workman, Delmar, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 163X — Carcinoma of lung with metastases to liver
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19 5/ to death, 19 ....., that (I) (we) last saw the deceased alive on 9/17 19 61, and that death occured at 11:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ernest Larmore M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/15/61

22c. PHYSICIAN'S NAME (Type): Dr. Ernest Larmore

22d. ADDRESS: Delmar, Del.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-17-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive

23d. LOCATION (City, town or county) (State): Delmar, Del.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. S. Manel Co - Delmar, Del

25a. REC'D BY REGISTRAR DATE SEP 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10868 — Reg. Dist. No. 10860

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mappsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

8-X-3

3. NAME OF DECEASED (Type or print): First Hattie — Middle — Last Young

4. DATE OF DEATH: Month 9 — Day 7 — Year 1961

5. SEX: F.

6. COLOR OR RACE: C.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1919

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter matthews

14. MOTHER'S MAIDEN NAME: Elizah Drummond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Milton Young — Address: Mappsville, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular
DUE TO: Disease
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive an _____, 19_____, and that death accurred at 5:15 p.m., fram the causes and an the date stated abave.

ACTUAL SIGNATURE: Wilbur R. Wells, Jr. M.D. — ADDRESS (Street, city or town, state): Salesbury, Md. — DATE SIGNED: 9-7-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-10-61

22c. NAME OF CEMETERY OR CREMATORY: Ist. Bapt. Cem.

22d. LOCATION (City, town, or county) (State): Mappsville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: Accomac, Va.

24a. REC'D BY REGISTRAR DATE: SEP 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSP[illegible] OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB